COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
January 12-13, 2015

Meeting Location: Sheraton Phoenix Downtown, 340 North 3rd Street, Phoenix, Arizona 85004

Commissioners Present: Chairman David Sanders, Amy Ayoub, Theresa Covington, Hon. Patricia Martin, Michael Petit, Jennifer Rodriguez, Dr. Cassie Statuto Bevan, Marilyn Bruguier Zimmerman

Attending by Phone: Susan Dreyfus, Dr. Wade Horn, Dr. David Rubin

Designated Federal Officer: Liz Oppenheim, executive director, participated via teleconference call and Amy Templeman, deputy director, participated in person.

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a meeting that was open to the public on Monday, January 12, 2015, from 8:30 a.m. to 5:30 p.m. and Tuesday, January 13, 2015, from 8:30 a.m. to 12:30 p.m. at the Sheraton Phoenix Downtown. The purpose of the meeting was for Commission members to discuss their understanding of the issues of defining and counting child abuse and neglect fatalities and to explore recommendations for addressing them. Commission members also discussed the work plans of the Commission subcommittees and the information that they have obtained to date.

Chairman Sanders indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. He indicated that any audience members wishing to comment could submit testimony or written feedback through the Commission's website.

MONDAY, JANUARY 12, 2015

Measurement Background, Discussion, and Recommendations

- The Measurement Subcommittee opened the meeting by revisiting the provisions of the Protect Our Kids Act of 2012, including the congressional finding that "deaths from child abuse and neglect are significantly underreported, and there is not a national standard for reporting such deaths." The act directed the Commission to study "methods of improving data collection and utilization, such as increasing interoperability among state and local data systems."

- The subcommittee's work is guided by the following questions from the Commission's work plan:
    - What are the purposes for counting child abuse and neglect fatalities?
    - What data on child abuse and neglect fatalities are currently collected? What are the limitations and costs of current data collection efforts?

- What short- and long-term strategies could be implemented to improve the counting of child abuse and neglect fatalities?
- Does reporting, including definitions of child abuse and neglect fatalities, need to be standardized? If so, how could this standardization be developed and implemented?

- The subcommittee then summarized testimony and research addressing these questions that has been presented to the Commission during the last year. Testimony from diverse stakeholders has presented the following recurrent themes about the challenges of securing a valid and reliable measurement of child abuse and neglect (CAN) fatalities:
  - There is no national definition or uniform classification system for CAN fatalities. Counting is further complicated in Indian Country.
  - Data submission to the National Child Abuse and Neglect Data System (NCANDS) by state child welfare agencies is voluntary, and the data submitted vary from state to state.
  - Not all localities or states use multiple data sources (e.g., death certificates, NCANDS, uniform crime reports, child death review teams) to enhance surveillance and measurement of CAN fatalities.
  - The type and utilization of joint investigations and multidisciplinary fatality review teams, especially those relying on a decision-tree matrix, vary greatly across states.
  - Definitions and standards of evidence for CAN fatalities are different in civil and criminal court proceedings than for child welfare.
  - The measurement of CAN fatalities is impacted by the training and qualifications of the person determining the cause and manner of death.
  - Fatal neglect is particularly complex and difficult to identify and quantify.
- The subcommittee emphasized that a valid and reliable count of CAN fatalities is critical to ensure consistency in counting from year to year and to determine whether prevention and intervention strategies are working. Despite the lack of a reliable count of CAN fatalities, there is widespread agreement that the overall number is significant and represents a serious public health concern.
- Although near fatalities were not included in the original charge from Congress, Commission members have heard extensive testimony about their significance. Consensus has emerged that these sentinel events warrant the Commission's attention and that this attention will support the Commission's goal to develop a national dialogue and actionable strategies. Therefore, the Measurement Subcommittee is working to develop recommendations related to both CAN fatalities and near fatalities.
- The subcommittee next addressed the studies and research they explored to develop draft recommendations presented to the Commission, including the following:
  - *A Nation's Shame: Fatal Child Abuse and Neglect in the United States* (1995) included recommendations that are still relevant today, including those related to child autopsy protocols, child death review teams, and joint investigations.
  - States are increasingly relying on multidisciplinary CDR teams, and every state now has a comprehensive CDR process. However, the composition and effectiveness of these teams are inconsistent. Forty-three states are submitting data from their CDR teams to the National Child Death Review Case Reporting System (CDR-CRS).
  - More than 40 states conduct internal child welfare reviews, which are usually initiated by the child welfare system when a child dies from child abuse. These child welfare-driven reviews are not multidisciplinary or multiagency.

- The Child Abuse Prevention and Treatment Act (CAPTA) requires that states put greater emphasis on utilizing multiple sources of data to determine their CAN fatality count and to involve citizen review panels (CRPs) in the review of CAN fatalities. Seventeen states combine their CDR teams and their CRPs to review CAN fatalities.
- States have vastly different definitions of near fatalities.

- Commissioners discussed the degree to which there is an undercount of CAN fatalities, but also to what degree there may be duplication within the count when multiple data sources are consulted (e.g., child welfare, law enforcement, domestic violence).
- Discussion then moved to a presentation of the subcommittee's draft recommendations. Chairman Sanders indicated that the Commission's ultimate goal is to achieve consensus on its recommendations. However, no formal votes were taken during this meeting. Instead, Commissioners were asked to indicate their general level of agreement with the proposed recommendations, ranging from complete disagreement to fully supportive and including the potential to request more detail and context before making a determination.
- In general, the recommendations suggest the need for and role of the federal government to prioritize the prevention of and response to CAN fatalities and near fatalities. Testimony at public meetings has repeatedly emphasized that whether a child's death or serious injury is counted as child abuse should not be "an accident of geography." In recognition of this, five of the seven overarching draft recommendations are directed at the role of the federal government, including the following:
  - Consolidate federal responsibility and leadership into a single agency to provide oversight, leadership, and guidance in development of CAN fatality and near-fatality investigation and measurement systems.
  - Establish in federal policy that the purposes for counting child abuse and neglect fatalities and near fatalities are (1) to understand the scope of fatal and near-fatal abuse and neglect; (2) to understand the implications for multiple systems working to respond to and prevent maltreatment; (3) to evaluate interventions; and (4) to develop policy and practice related to child well-being.
  - Rapidly design and validate a national standardized classification system to include uniform definitions and a multidisciplinary process.
  - Build a national child maltreatment fatalities data repository system and expand/standardize fatalities reporting into NCANDS.
  - Improve the system of child death investigation and death certification by developing standards of investigation and expertise in investigation and certification.
- Discussion of these recommendations included the following key points:
  - There was some discussion about which federal agency should serve as the lead for a consolidated effort. Subcommittee members indicated that they were not identifying a specific agency at this time. Commissioners were cautioned that a multitude of congressional directives exist that would need to be consolidated and coordinated.
  - Subcommittee members explained that the suggested data repository was envisioned as a central place for data to be submitted about CAN fatalities and near fatalities. Some segment of this data would be reported to NCANDS based on new standards and mandates (for example, children who were known to the child welfare system or who were receiving child welfare services at the time of the fatality/near fatality).
  - When additional data points are requested of states, there is a regulatory review process that includes projecting the burden on states to produce such data. It was suggested that

the subcommittee first determine whether any additional data requested is already being collected elsewhere and that any such requests be specific enough for states to comply without undue burden.

- A concern was raised that the draft recommendations did not speak to tribes as sovereign nations. There is a need to be more intentional and explicit on this front, including recognizing the limited number of CDR teams in tribal communities. The Measurement Subcommittee will continue to recognize and work with the American Indian/Alaska Native (AI/AN) Subcommittee to address the unique needs of AI/AN communities.
- Discussion about the recommendation to validate a national standardized classification system included questions about whether the Department of Defense's (DoD) system has been validated for populations beyond the military and designed specifically to deal with CAN fatalities.
- Another point of concern was that there was no identification yet of the resources that might be attached to the recommendations. Some Commissioners noted that part of the reason for putting forth a more reliable count of CAN fatalities would be to demonstrate the need and determine whether sufficient resources currently exist to address the need. It was noted, however, that resources are not solely financial. Some discussion followed about how child welfare services are financed overall and the current status of federal finance reform.
- Commissioners discussed the recent enactment of the Sudden Unexpected Death Data Enhancement and Awareness Act (P.L. 113-236). This legislation, as introduced, was comprehensive in scope and included specific program funding. However, the enacted legislation was narrower in scope. Commission members agreed to seek additional insight into the legislative developments and decisions surrounding this legislation, to inform their own recommendations.
- One suggested additional recommendation was to strengthen congressional oversight of preventing, responding to, and measuring CAN fatalities and near fatalities.

- The subcommittee put forth two draft recommendations directed at the states:
  - Consolidate state responsibility and leadership concerning CAN fatalities into a qualified state health/medical office.
  - Mandate that states participate in the national child maltreatment fatalities data repository system and report to NCANDS all fatal and near-fatal maltreatment that meets the criteria of the standardized classification system.
- Discussion of these draft recommendations included the following key points:
  - Commissioners discussed the differences among states in who determines the cause and manner of death, as well as the differences between medical examiners and coroners. The subcommittee's recommendation was as follows: "Encourage states to transition from coroner systems to medical examiner systems. Facilitate this transition by expanding pathology training programs to train more forensic pathologists, and increasing funding for medical examiner facilities, equipment, staff, and training." Enhancing this decision-making process, as well as the quality and standardization of death-scene investigation, is central to improving the count of CAN fatalities.
  - The subcommittee also indicated that they envision a state-level health official who would be responsible for overseeing the creation of a more robust data repository, rather than this data being housed within the child welfare agency. This will be a critical step toward taking a public health approach to CAN fatalities and near fatalities.

- Given that the draft recommendations have a significant focus on the role and value of CDR teams, Commissioners sought to understand the nature and overlap of the various reviews that occur in local communities and across states.
    - There is currently no model or standard for a state CDR team. Such teams are in place in 49 states, but their quality and composition vary greatly.
    - The subcommittee has been impressed with the work of the Air Force and feels that its multidisciplinary process of relying on a more objective decision-tree tool could prove beneficial to existing CDR teams. Members emphasized that the goal is to strengthen and standardize local review teams, including with regard to the types of fatalities and near fatalities that they review.
    - A question was posed about how the Commission's recommendations would influence states that have ombudsman offices, some of which are charged with conducting independent reviews of CAN fatalities. The subcommittee was cautioned to ensure that recommendations invite clarity rather than confusion on this issue.
- Commissioners agreed that in general this subcommittee and its recommendations are headed in the right direction, with a few caveats, including an acknowledgment that the proposed recommendations do not yet fully address tribal concerns. The subcommittee will develop a proposed process for identifying a more accurate number of annual CAN fatalities and will bring this back to the full Commission for consideration.

American Indian/Alaska Native Subcommittee

Commissioners Martin and Zimmerman presented a summary of testimony heard so far about AI/AN issues and some very preliminary recommendations of the AI/AN Subcommittee. This subcommittee plans to present a full agenda of testimony on Native American issues at the Arizona Public Meeting in March. Key points from their presentation include the following:

- The birth rate for AI/AN people in the United States is higher than for other races. This is a young and growing population. However, Native children and youth also face the highest death rates of all racial/ethnic groups.
- The major areas of focus for this subcommittee so far are jurisdictional issues, data collection, and CDR teams.
- Jurisdictional issues:
    - Commissioners Martin and Zimmerman spoke with Vice Chancellor Carole Goldberg at UCLA, who said there is "no bottom line about jurisdictional issues." Approximately 20 states have MOUs with local reservations, so that if the perpetrator is living on the reservation, the tribal court will take jurisdiction. If not, the state has jurisdiction. But even in these cases, due to resource issues, tribes will sometimes defer to the state.
    - The subcommittee is still looking for some common ground that might be proposed for the sake of improving the consistency of counting child abuse and neglect fatalities of AI/AN children.
    - It is not as simple as giving jurisdiction consistently to the tribe, because there is such variability in available resources.
    - Often, fatality cases in Indian Country or other small, rural communities are taken to a higher (state or federal) level because these higher courts have the ability to impose stricter sentencing.

- The recommendations the subcommittee has seen so far come from the Tribal Law and Order Act, the reauthorization of the Violence Against Women Act, and a report called "Ending Violence so Children Can Thrive." These all focus on building local capacity and empowering tribes to provide investigative authority, so that when a child dies, the ability to seek justice does not depend on where the family lives or where the child died.
- One of the subcommittee's three primary preliminary recommendations to the Commission will be to look at creating interdisciplinary investigatory teams in Native communities.
- There are questions about where federal support for CAN fatality efforts should be housed in Indian communities, because it needs to be in an agency that is consistent across Indian Country. For rural communities, that would be within the Bureau of Indian Affairs (BIA) or the Indian Health Service (IHS), but for urban Indians things will look different.
- The AI/AN Subcommittee is planning to talk to Judge Bill Thorne in Utah, another expert in jurisdictional issues.

- Data collection/counting:
  - The best way to count fatalities in general appears to be through a CDR process; however, most Indian territories do not have such a team.
  - The Commission has learned that it is better to have more than one source of fatality data. One possibility is to look at what is already happening on reservations—for example, what would it look like to train IHS providers on reservations to conduct forensic investigations?
  - Data is a sensitive issue for tribes for a number of reasons. States sometimes use tribal data to demonstrate need for block grants, but the money and help obtained do not ultimately benefit the tribes. Data also contributes to the pathologizing of tribal people. Tribes are very sensitive to the question of who owns their data.
  - Data is needed in order to develop effective interventions. But given these historical issues, the question is how to gather the data respectfully and show tribes that this will benefit them.
- Intergenerational trauma sometimes complicates the ability to identify causes for fatalities (for example, trying to pinpoint the "reason" for a youth suicide).

Commissioner Discussion

Commissioners' questions and comments yielded the following additional points:

- The AI/AN Subcommittee also will be looking into effective services to reduce and eliminate fatalities (time permitting). But the jurisdictional and counting issues must come first.
- The Fostering Connections Act enabled tribes to receiving funding under title IV-E. There was a discussion about whether the federal government could require or request that tribes receiving IV-E funds provide certain data and/or meet certain quality standards for CDR teams. It was suggested that any requirements for tribes should not be greater than what is required by states receiving the same funding.
- Jurisdictional issues are very complicated and bigger than child welfare alone. The Commission likely will not create a simple solution, but it can perhaps communicate why these issues are so important and recommend a way to start approaching them.

- It is challenging to identify "best practices," because most practices have not been developed and evaluated specifically for Native children and families. The Commission will look at existing promising practices developed by and for tribes.
- Tribes must be involved in the development of any quality standards. As sovereign governments, tribes cannot be ordered to do things, but they can and should be invited to participate.
- Consider looking to the federally funded maternal and child health epicenters for the tribes—they may have already tackled some of the same data collection issues.
- Many state child welfare agencies are still wrestling with implementation of the Indian Child Welfare Act (ICWA).
- There appear to be two possible ways the Commission can address jurisdictional issues:
    1. Identify the best recommendations for resolving these issues based on the opinions of a majority of experts.
    2. Begin by talking about the needs of children and families on reservations, and recommend that because of all of these issues, the federal government needs to put some resources into resolving jurisdiction questions. In the meantime, recommend that systems that are currently collecting data from tribes share this data so that a more accurate number of CAN fatalities in Indian Country can be identified.
- A third option is to explore the implications of several potential recommendations.
- The Commission is in general agreement about the direction of this subcommittee and the three areas (jurisdiction, data collection, and CDR) it is currently pursuing.

CPS Subcommittee

Commissioner Petit began the discussion with some overarching issues about child protective services (CPS):

- Whether a child is protected or not is determined in many instances by which jurisdiction they live in. For example, some jurisdictions see more abuse and neglect and therefore have more resources in place to address it.
- States do not currently report all deaths of children known to CPS, resulting in an undercount. NCANDS captures child deaths from only two categories: children from families that have received family preservation services in the last five years and children from families that were reunified in the last five years. To get a more accurate count, the subcommittee discussed a broader approach that would include children whose caregivers or siblings had been the subject of a prior report, as well as families that were screened out or that had unsubstantiated cases.

The CPS Subcommittee identified four main themes of their work so far. The themes and the issues raised in discussion included the following:

1. **Safety assessments**
    - Safety decisions are the most critical decisions made by child welfare systems, and every system uses safety assessment tools. But there is no scientific evidence to show that tools currently in use can identify children at risk of serious harm or death. Current tools yield both false positives and false negatives, and professionals using the same tool can end up with different recommendations for the same family.

- There is a difference between risk and safety assessment. Safety assessments are designed to help trained professionals identify families with an immediate safety risk that could cause substantial harm or death to a child. Risk assessments are more forward looking and designed to capture the likelihood of maltreatment within one to two years.
- A Texas child fatality study looked at family history before a child death to identify key signals that may have been missed, including risk factors that appeared less serious at the time and were easy to overlook.
- CAPTA funds research-based safety tools, but the subcommittee is not aware of any in the development stage.
- In making child welfare decisions, safety considerations can be combined with information about a family's protective factors.
- Many investigations concern older youth who run away or are truant from school. Does this take a state's focus away from prevention of fatalities?
- It is important to ensure that protective factors also are considered in the context of these tools. Tools should not completely replace clinical judgment and critical thinking.

2. **Workforce and workload issues, including turnover**
    - Resources are key here, influencing the number of workers hired as well as caseload size.
    - Training and procedural issues also are critical.

3. **Practice and evidence-based programs that impact child maltreatment fatalities**
    - There are virtually no evidence-based programs proven to prevent fatalities. Rapid Safety Feedback (in Florida) is promising, but no other strategies have been presented to the Commission so far that offer promising evidence around preventing fatalities or sufficient structure and documentation for replication.
        - The subcommittee suggested looking at what has been learned about practice in jurisdictions with lower fatality rates.
        - Questions:
            - Should the subcommittee send a letter to all 50 states asking whether they have developed programs they believe are effective in preventing fatalities?
            - Are current substance abuse, mental health, and domestic violence services effective in preventing fatalities?
            - Are families referred to the right services?

4. **System resources**
    - CPS, as distinguished from foster care, is underfunded. The exact amount of federal funds earmarked under CAPTA for CPS is unknown, but it is probably under $200 million, compared to some $30 billion for out-of-home placement services.
    - Discrepancies in spending from jurisdiction to jurisdiction influence the quality and quantity of available services.
    - Federal finance reform could give jurisdictions more flexibility in spending child welfare dollars.

- In resource-poor communities, workers are likely to tolerate a higher level of risk or neglect because they lack service options. This is particularly true in tribal communities. Kinship care may not be possible due to multigenerational substance abuse or mental health issues, and removing children from the tribal community is contrary to the Native American belief system.

Along with the discussion about these four areas, Commissioners identified several larger cross-cutting themes and questions:

- A more intensive focus on children at greatest risk of fatalities would have the biggest benefits. Commissioners identified three groups:
  - Very young children, under age 2 or up to age 5 (In Washington State, all calls about children under age 2 are automatically screened in. Michigan's policy automatically screens in a family with three calls on a child under age 4.)
  - Children placed in foster care with nonrelatives
  - Youth who are trafficked
- The importance of a multidisciplinary approach was a theme that ran throughout the discussion and included the following points:
  - CPS is a 911 call center. What happens following that call has to work as part of an overall safety net that is larger than CPS.
  - A multidisciplinary response, starting with investigation, is important to reach those at greatest risk in order to get a full picture of a family's safety needs and the various systems with which they may be involved.
  - Multidisciplinary responses should be studied to build a body of evidence of what works. The subcommittee is looking into child advocacy centers as a model. Other suggestions included a multidisciplinary look-back at families in which children died. Do reviewers from different disciplines find issues that could have alerted the system to dangers?
  - Based on what is already known, what action steps could build on the momentum around multidisciplinary, shared-responsibility, place-based work?
  - Should the Commission recommend that all states develop a multidisciplinary plan to reduce fatalities? This suggestion could build state ownership.
- What should be the role of the community and community-based organizations? What incentives could be offered to support better partnerships with the community?
- Nationally, data on recurrence of maltreatment has shown improvement, and the number of substantiated cases has dropped. Does this mean anything in terms of child fatalities?

Disproportionality Subcommittee

To date, the Disproportionality Subcommittee has taken the following actions:

- A review of past commission and GAO reports to identify any recommendations that deal specifically with minorities, ethnicity, or cultural identity.
- Preliminary conversations with the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Commissioner Martin summarized what has been learned to this point and asked for feedback regarding the future direction of the subcommittee. Discussion included the following key points:

- Some of the recommendations identified include the following:
    - Provide support to researchers to look at what is important for ethnic/cultural minorities in child welfare agencies and how that may relate to CAN fatalities.
    - Implement joint criminal investigation teams within military branches and Indian nations for cases of child abuse and neglect that touch cultural or ethnic minorities.
    - Create teams in these jurisdictions that identify specific issues and factors that come up in child death reviews regarding minority families.
- Questions for the subcommittee to explore:
    - What are the specific issues that affect minorities? Anecdotally, it seems that there is something disproportionate happening with the quantity and quality of care received by minority families.
    - If there is agreement that overrepresentation of minorities is a reality, what can the Commission do to minimize the deaths that these children are experiencing?
- The next step seems to be to identify what research exists to address these questions; what is already known about these issues?
- One suggestion was to look at infant mortality rates stratified by race, as well as research on adverse childhood experiences (ACES) and specifically the impact of racism on long-term outcomes.
- Another question to explore is the role of poverty vs. race. Poverty does not cause maltreatment, but it does cause stressors, and there are intersections between those stressors and maltreatment. In some cases, there are differences in how agencies respond to different groups. However, it is likely not enough just to look at the child welfare agency and what they are or are not doing. A multidisciplinary response will be needed to shore up stress responses in poor households.
- Agencies need to ensure that families' cultures are respected and that children are exposed to their own culture, regardless of what family they live with. Agencies can establish policies and procedures that help all adults (all of whom have biases, conscious or unconscious) make good decisions for families and children.
- It will be difficult to reduce or eliminate fatalities unless the Commission understands and addresses the issue of disproportionality in the death rate for minorities.
- Providing adequate support for kinship care and other informal supports for families may be another area to strengthen, in order to create communities in which children do not "slip through the cracks."

TUESDAY, JANUARY 13, 2015

Public Health Subcommittee

The Public Health Subcommittee has developed a work plan that reflects the subcommittee's intention to take the wider lens of a population health approach to look beyond CPS. They are working to identify specific non-CPS programs that have an investment in preventing child abuse and neglect fatalities.

The subcommittee has identified a few key questions:

- How does the science of prevention align with current federal and state policies and programs? How can the Commission understand the current state of the evidence with respect

to prevention, and how might that inform the Commission's recommendations to eliminate CAN fatalities?

- To what extent do state and federal programs currently address CAN fatalities? What are the areas of overlap among programs? How can these connections be strengthened within agencies and across agencies at the state and federal levels?

By looking at these two questions, this subcommittee will address the portion of the Commission's overall work plan that addresses identification of promising prevention strategies across disciplines. Including the following questions:

- Are states or federal agencies using innovative ways to leverage funds across funding streams to prevent child abuse and neglect?
- What knowledge gaps exist that require further research?
- What is the alignment among research, policy, and practice?

The subcommittee's first task was to identify state and federal programs that often touch families where there is a fatality or near fatality due to child abuse and neglect:

- Members are holding a number of meetings with representatives of these programs to build support for the Commission's work and identify potential recommendations.
- One such meeting was with representatives of the Health Resources and Services Administration (HRSA) in November 2014. This office is responsible for federal home visiting programs, as well as emergency medical services, the Maternal and Child Health Bureau (MCHB), and child injury data collection, among other programs. There is some potential to explore how expectations around preventing CAN fatalities could be included within the MCHB block grants.
- A meeting was held with the Centers for Disease Control and Prevention (CDC) in Dec 2014. They have made some grants to states around child abuse and neglect prevention, but their overall footprint in this area is rather small.
- There is a big meeting scheduled with the Centers for Medicare and Medicaid Services (CMS) in January 2015, to consider opportunities within Medicaid and put together a CMS briefing for the full Commission.
- Meetings are still being scheduled with the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), and OJJDP.
- On the state side, the subcommittee is involved in putting together panels on the public health approach to child maltreatment prevention for state public hearings.

The subcommittee's second area of focus is to assess the strength of existing prevention programs, including place-based prevention, home visiting (the federal MIECHV program and Nurse-Family Partnership, among others), Triple-P, and SafeCare. Commissioners Dreyfus and Rubin also met with Jack Shonkoff at the Center for the Developing Child, who had suggestions about potential dual-generation reimbursement strategies in Medicaid.

Discussion among Commissioners raised the following key points:

- Home visiting, in particular, falls into the "promising" category for reducing child fatalities, particularly those from lack of supervision. Other programs' (e.g., Triple P and SafeCare) outcomes are more proximal, with their primary impacts being on recidivism. The most promising strategies seen by the Commission so far are the collective community response in El Paso County, Colorado and the use of predictive analytics in Tampa, Florida.

- Two other promising strategies include a child protection center in Wisconsin that conducts a multidisciplinary review of high-risk cases (not just fatalities), and the engagement of child advocacy centers to respond to screened-out CPS calls. No research is yet available on either of these approaches.
- Requiring states to report on the reduction of child abuse and neglect fatalities as part of their MCHB state grants would force states to look beyond the child welfare system to the community at large to prevent these fatalities and could be a promising approach to force a broader discussion of this issue at the state and federal level. This would still allow individualized approaches by states, with the federal government setting the standard. There is precedent for this in home visiting, which was moved to HRSA in an effort to create a more proactive rather than reactive system.
- The CDC has provided Essentials for Childhood grants in five communities that are focused on prevention of maltreatment along the lines of what the Commission is discussing. The CDC also funded a study by the Children's Safety Network to assess how MCH directors around the country viewed their role in child maltreatment and fatality prevention. Although they saw their current role as being fairly limited, there was a high level of interest among those interviewed in becoming more engaged as a prevention partner.
- How states are taking advantage of provisions in the Affordable Care Act (ACA) will be the topic of the subcommittee's upcoming meeting with CMS (along with multigenerational and dual reimbursement strategies). The ACA contains several potential policy levers, including a prevention fund and an innovation center within CMS to test, evaluate, and expand payment structures and methodologies to achieve better outcomes.
- Two issues within Medicaid will need to be considered in any efforts to make that system more preventive: (1) There are both mandatory and optional services for states, and preventive services like the Commission is talking about are currently not on the list of mandatory services. Therefore, they are most likely to be cut by states when finances are tight. (2) State budget cycles are 1-2 years, so that's how actuaries are scoring impact. Is there an opportunity to get CMS to re-think what is on the mandatory services list, given the evidence in support of prevention?
- The subcommittee was encouraged to explore whether the National Institute on Alcohol Abuse and Alcoholism (or other agency) has conducted any research on the connections between substance abuse, mental health, and child maltreatment fatalities, and to make sure that any discussion of these issues is inclusive of fathers and other neglected subpopulations. One study in Washington State demonstrated that many substance abusing mothers who received Parent-Child Interaction Therapy and motivational interviewing no longer needed substance abuse treatment.
- The CPS and Policy Subcommittees are looking specifically at family preservation and family support programs, which the Commission is mandated to assess.
- Evidence is currently scarce to establish which preventive programs are most effective. Several reasons for this were discussed, including a lack of research funding designated for evaluation in the child maltreatment field. Everything in the Commission's report will not be able to be evidence-based, but this lack of a knowledge base needs to be highlighted within the report, along with recommendations for how the evidence base can be further developed.
- Commissioners considered what (if any) formal mechanisms exist to disseminate effective practices within child welfare and beyond. Such mechanisms will be critical for an effort like this Commission to accomplish its goal.

- It is important to look at how communities plan and coordinate across systems and touch points (family members, pediatrician, WIC, home visiting programs) to create a tightly woven community fabric. This may be more important than finding a "magic bullet" evidence-based program.
- Child safety is at least in part a question of community resources. The Commission is requesting more information about state budgets and programs, and how the outcomes vary state to state. Commission staff are working with the Policy Subcommittee to put together some information about how child maltreatment rates correlate with state child welfare expenditures.
- There is a significant gap between the high number of families at risk for a child maltreatment fatality and the smaller number of families who meet the legal criteria for state intervention. This gap will need to be addressed in the Commission's recommendations.
- Families who are reported to CPS but screened out appear to be at increased risk of fatality, according to research from California. The hotline or initial screening call is not an aspect of CPS that receives a lot of attention at the federal level. This raised the question of how many of the children referred to as "not known to the system" are in fact subject to screened-out hotline calls (for that child, or for someone else in the family). In some states, these data are protected by privacy laws. The Commission determined that this issue will be further explored by the CPS Subcommittee.
- There was some discussion about coordinating information requests to government agencies among the various subcommittees, to avoid duplication.
- It was recommended that the Commissioners look at the state assurances required by CAPTA, because states are supposed to ensure referral of children not at imminent risk of harm to appropriate community resources, but this is not currently happening.

Military Subcommittee

The Military Subcommittee reported that its work is in a holding pattern while the DoD determines who should meet with Commissioners (military or civilian, which branches or departments, etc.).

The Army's Family Advocacy Program (FAP) and research branch are supportive of working with the Commission. The Military Subcommittee also is working with the DoD's main Office on Family Advocacy (OFA)—this is the division that provides support services and conducts investigations and determinations (like a civilian CPS agency), as well as providing services for family violence and domestic violence. Each branch has a Family Advocacy office; all branches report up to the main office in Washington, DC.

Plan to move ahead:

- The subcommittee is creating a list of questions that the central OFA will send out to all branches. These will be presented and discussed when the different branches come together in March for a three-day meeting.
- Conversation will proceed with the Army's research division in a parallel way. Commissioner Rubin is pulling some data related to military families to present and get their feedback.
- One significant area of concern for FAPs is the confidentiality restrictions that prevent them from working well with state and local CPS agencies. The branches have robust prevention services for these families, once identified, but families often are not identified because of these restrictions. A staff member within the OFA is working state by state on this issue.

- The subcommittee wants to learn more about the prevention services that have been developed within the branches, some of which are quite robust. For example, the Navy has strong shaken baby syndrome prevention and safe sleep programs.
- OFA is concerned about how issues related to deployment have impacted child fatalities. Soldiers are coming home with poor attachments to their babies and being left alone with them too quickly. Isolated caregivers left home alone with small children while their spouses are deployed also raise concern.
- The subcommittee will be formalizing a set of questions in the next month or two. Members are very happy with the level of cooperation they have received thus far from military branches.

Policy Subcommittee

The Policy Subcommittee intends to track very closely to the Commission's purpose as described in the Protect Our Kids Act. They will be looking at four program elements: effectiveness, accountability, efficiency, and collaboration.

- Effectiveness
  - The subcommittee will be looking first at effectiveness of existing programs, focusing on titles IV-B and IV-E, as well as CAPTA: What's working, what doesn't work, and what is not being implemented as written in statute.
  - They also will be looking at the CFSRs, particularly at the lack of data around fatalities.
  - They will be examining the bypass of reasonable efforts provision in the Adoption and Safe Families Act (ASFA) and why it is not being used.
  - Because babies are most vulnerable to CAN fatalities, and they are also the ones most likely to be identified as being at-risk at the hospital, the subcommittee will look at CAPTA's "safe plan" requirements (originally limited to children born to substance-abusing parents).
  - The subcommittee is interested in learning more about how title IV-B funds and the Social Services Block Grant (SSBG) are being used.
- Accountability
  - The subcommittee will conduct a complete review of federal programs and policies to identify federal authority and accountability related to prevention: What are the funding streams, and are they producing the outcomes for which they were intended?
  - The next step will be to look more at state accountability. States are failing to meet certain federal requirements, and there is a desire to hold them accountable while at the same time continuing to allow them flexibility to do things in the ways that make the most sense for their state. Are there opportunities to elevate reduction of child mortality as a goal for some of the larger programs?
- Efficiency
  - In the debt-ceiling law of 2010 there is a provision that requires GAO to identify programs, agencies, and initiatives that have duplicative goals and activities. So far none of the programs the Commission is looking at are on that list, but it will be important to identify whether and where duplication exists.
  - There was considerable discussion among Commissioners about the reasons for looking for programmatic duplication and the potential consequences of identifying such programs. The goal is not to eliminate needed programs or funding but to be responsive to the

current policy landscape (including interest in block grant funding), address any efficiency issues at the federal level, and ensure that services are prioritized effectively.

  - The Commissioners were urged to consider further integration of existing programs and systems to achieve desired outcomes, rather than focusing on the effectiveness of individual, isolated programs.
  - The Policy Subcommittee also was cautioned to be clear about what exactly is meant when a program is said to be "not working."

- Coordination/Collaboration
  - The Policy Subcommittee would like to identify key federal partners and determine whether and to what extent they work together.
  - Little evidence is currently available about duplication of and collaboration among programs and services. What are the strengths and weaknesses of existing programs, and how can these programs be better supported?
  - There was some discussion about what the role of the federal government should be, and whether the Commission should spend time delineating the current forms and functions of the federal government, or instead say what it believes the federal role should be and let Congress and the President determine the form that should take.
  - The subcommittee will look into what GAO can provide in terms of support for some of the information-gathering that needs to happen.
- Future Areas to Explore
  - The subcommittee will look at criminal laws and policies regarding CAN fatality at the state level—how it is defined, what happens with the ASFA bypass of reasonable efforts, what happens to siblings and perpetrators. Several Department of Justice studies were mentioned that have looked at sentencing and perpetrator outcomes.
  - Explore the feasibility of standardizing state definitions of child abuse and neglect for program purposes, in addition to counting. Is CAPTA the best vehicle to establish that?
  - The role of the federal government will continue to be discussed within subcommittees, in the context of testimony presented to the Commission and proposed recommendations.
  - The Policy Subcommittee will look at the implications of the Commission's proposed recommendation to create a single, standardized definition of CAN fatalities for counting purposes.

The meeting adjourned at 12:30 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

_____

David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

4/12/2015

_____

Date